Quality Practice Framework in the Prevention and Management of Persistent Pain

KNOWLEDGE AND SKILLS FOR STANDING IN OSTEOPATHY AUSTRALIA'S PAIN MANAGEMENT CLINICAL PRACTICE GROUP (CPG)

Improving outcomes for patients

Persistent pain is a major health problem affecting one in five Australians.

At least 70,000 Australians consult an osteopath each week, and many within this group do so for help with their pain.

As primary health care practitioners, osteopaths help prevent the burden of persistent pain by identifying early signs and risk factors and facilitating optimal management in conjunction with the patient's GP and other health professionals.

The osteopathic profession

Osteopaths in Australia complete a double Bachelor or a Bachelor and Masters qualification at an accredited university and are registered with the Australian Health Practitioner Regulation Agency (AHPRA).

Osteopathy Australia is the peak professional body, representing approximately 90% of registered osteopaths in Australia. The osteopathic profession is becoming increasingly diversified, with many members of Osteopathy Australia completing further tertiary qualifications in specific areas of clinical practice to expand their clinical skills. Others, through dedicated experience have developed core competencies and skills relating to specific clinical issues and patient groups.

Promoting clinical excellence osteopathic practice

To facilitate excellence in inter-disciplinary care between osteopaths and other health professions, the development of quality clinical practice is vital.

Designing Continuing Professional Development (CPD) pathways that promote key skills and competencies in specific areas of practice and processes that recognise members with standing in areas of practice is a priority for Osteopathy Australia. This strategic focus will build on and complement Osteopathy Australia's Statement of Scope of Practice in Osteopathy.

This framework acknowledges that the knowledge, skills and scope of practice of osteopaths with a focus in pain management vary depending on education, workplace requirements, clinical team requirements, and relevant industry policies. It is not intended to define all knowledge sets and skills possessed by these osteopaths, nor all interventions these practitioners offer.

The framework relates to Osteopathy Australia's Pain Management Clinical Practice Group (CPG). It outlines knowledge and skills that the organisation expects osteopaths seeking standing and recognition within this group to possess as a minimum requirement. This framework is not mandatory and pertains only to members of the CPG.

The framework has been informed by patient demand, workforce planning needs, targeted consultation with relevant industry stakeholders and the osteopathic profession. It is a living document and will be revised to align with developments in evidence-informed practice, patient need, clinical reasoning and standards, patient and workforce planning need.

It is written in alignment with the International Association for the Study of Pain's Declaration of Montreal and Australia's National Pain Strategy. The declaration and strategy recognise pain management as a fundamental human right and prioritise mitigation of persistent pain through a range of methods that include management of both acute and chronic pain conditions through suitable early intervention.

This framework recognises the role of inter-disciplinary support in persistent pain, and acknowledges the overlap of many of the clinical competencies to all health professionals in pain management.

The framework uses pre-validated definitions relating to states of persistent pain that are taken from the International Association for the Study of Pain 'IASP Taxonomy' 2016. Refer to the Appendix. This framework expects members of the Pain CPG to demonstrate skills and competencies aligned with those recommended by the International Association for the Study of pain in its various curricula for pain focused allied health practitioners.

1. Osteopathy Australia, 'Statement of Scope of Practice in Osteopathy' [online]; https://www.osteopathy.org.au/files/Documents/Advocacy/Scope%20of%20practice%20in%20Osteopathy%202018%20FINAL.pdf

2. Pain Australia, 'The National Pain Strategy', Executive Summary, 2010 [online]; http://www.painaustralia.org.au/advocacy/national-pain-strategy.html

3. International Association for the Study of Pain, 'Declaration of Montreal' [online]; https://www.iasp-pain.org/Advocacy/Content.aspx?ItemNumber=1821

Extended Practice Membership

Extended practice members undertake a pathway of structured continuing professional development to practice the osteopathic scope more fully, beyond entry or initial levels of practice undertaken in patient management. These members demonstrate skills that enhance the delivery of pain management interventions and encourage clinical quality in those services. They demonstrate application of a range of intermediary and complex clinical reasoning skillsets in the focus area.

Extended practice members work toward full acquisition of the following clinical knowledge sets.

1.1 Knowledge of the natural course and resolution of acute pain and biological, psychological and social factors that may predispose an individual to poor prognosis when an acute injury is sustained. This would include knowledge of valid tools that can be applied to determine risk in acute pain (including OMPSQ), their purpose, use, interpretation and integration in clinical reasoning and patient management.[4]

1.2 Knowledge of clinical indicators, symptoms and clinical presentations associated with nociceptive pain; neuropathic pain; visceral pain; and cancer pain.

1.3 Knowledge of current general pain inventory tools (for example EPPOC)[5], their purpose, use, interpretation and integration in clinical reasoning and patient management.

1.4 Knowledge of critical domains and considerations in formulating a patient-centred biopsychosocial management plan for pain.

1.5 Knowledge of suitable health professionals and other professions included in pathways of referral for further assessment and management of a pain presentation where indicated.

1.6 Knowledge of the impact of practitioner communication approaches, including language and consultation styles in successful resolution or perpetuation of pain in the current science.

1.7 Knowledge of the role of pain education frameworks in patient reconceptualization and their effectiveness in arresting the transition from acute to persistent pain and in modulating persistent pain in the current science.

Extended clinical reasoning in practice

Consistent with national and international best practice in pain management and in line with the need to prevent chronic pain through suitable early intervention, extended practice members of the Pain CPG demonstrate awareness of and ability to apply standardised pain assessments to identify biological, psychological and social risks of chronic pain and complexity in the acute phase.

4. Osteopathy Australia endorses standardised assessments of the International Association for the Study of Pain in manual therapy. See IASP curriculum outline for pain for physical therapy, page 8

5. NSW Health, Agency for Clinical Innovation (ACI); [online] http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/assessment

Members demonstrate the capacity to establish the cognitive and emotional state of the individual, and identify chronicity risk as relating to the health system, patient affect, age, sex, activity levels, occupation, family, lifestyle, or comorbidity using validated tools, screenings and consultation approaches to extract patient pain narratives.

Members exemplify the capability to develop acute pain management plans and to use referral pathways indicated in clinical best practice to promote healing and improve function, including for aspects such unhelpful thoughts and behaviours and/or perpetuating social and lifestyle factors in acuity.

In management planning, extended practice members demonstrate that they can incorporate an appropriate balance between passive treatment or evidence informed appropriate manual therapy (where indicated) with patient self-management approaches and pain education program delivery. In pain education programming, extended practice members exemplify the ability to identify, assess and incorporate health promotional resources to wherever possible enhance self-care.

Advanced Practice (Titled) Membership

Advanced practice members demonstrate long-term commitment to sustained practice in pain management. Through further higher education and quality clinical review, these members demonstrate ability to provide pain management advice and interventions that extend beyond the scope of osteopathic practice and are more broadly offered by other professions with a primary focus on pain management.

Advanced practice members possess the following clinical knowledge sets.

Pain and its mechanisms

2.1 Knowledge of different clinical conditions and diagnoses that can influence persistent pain and mimic neuro-musculoskeletal disorders.

2.2 Knowledge of physiological and psychological responses associated with acute pain, as well as of deviations to normal response ranges.

2.3 Knowledge of pathogenesis and neuro-physiological mechanisms, including intrinsic and extrinsic contributors in nociceptive pain; neuropathic pain; visceral pain; and cancer pain.

2.4 Knowledge of neuro-plastic changes in the progression from acute to persistent pain, concerning alterations in:

- Visceral pain mechanisms
- Somatic pain mechanisms
- Neuro-biological mechanisms
- Cognitive processes
- Mood/emotions
- Behavioural/psychological processes.

2.5 Knowledge of neural and musculoskeletal contributors in peripheral neuropathy.

2.6 Knowledge of central nervous system changes that can result from peripheral injury or pain.

2.7 Knowledge of peripheral and central sensitisation in acute and persistent pain in current pain science for nociceptive pain; neuropathic pain; visceral pain; and cancer pain.

2.8 Knowledge of persistent pain risk factors by population group, socio-economic status, or individual patient context.

2.9 Knowledge of relationships between co and multi-morbidities, pain onset, complexity and persistence.

2.10 Knowledge of predictors of further clinical complexity in advanced nociceptive, neuropathic, visceral and cancer pain.

Assessment

2.11 Knowledge of safety principles in evidence - informed pain assessment from the current science.

2.12 Knowledge of current evidence informed neurological testing methods for identifying potential lesions of the central nervous system (modified quantitative sensory testing) in a persistent pain presentation, their purpose, use, interpretation and integration in clinical reasoning and patient management.

2.13 Knowledge of the range of current self-reporting measures[6] used to assess people with specific types of persistent pain, their purpose, use, interpretation and integration in clinical reasoning and patient management.

Clinical management

2.14 Knowledge of evidence informed intervention strategies for neuro-musculoskeletal contributors to persistent pain and their relative and absolute contraindications.

2.15 Knowledge of physiological processes that may support reparation of affected nerves in persistent pain.

2.16 Knowledge of the effectiveness of interdisciplinary clinical interventions offered by other health practitioners, their role and use in clinical practice.

2.17 Knowledge of evidence informed self-management models; including principles in pacing prescription and management with graded exposure principles.

2.18 Knowledge of the role and effectiveness of lifestyle adaptations in persistent pain management from the current science.

2.19 Knowledge of evidence informed principles in effective pain education program development.

2.20 Knowledge of evidence informed principles in the prescription of exercise for persistent pain, from both a safety and outcomes perspective.

2.21 Knowledge of basic dynamic approaches to identifying and managing poor patient perceptions of pain, including basic cognitive behavioural approaches and/or acceptance and commitment approaches.

6. NSW Health, Agency for Clinical Innovation (ACI); [online] http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/assessment

2.22 Knowledge of limitations of manual therapy interventions for persistent nociceptive pain; neuropathic pain; visceral pain; and cancer pain.

Advanced clinical reasoning in practice

Advanced (titled) members perform multimodal pain assessments and differential pain diagnoses, using via patient self-reporting instruments, cognitive behavioural and narrative based approaches, neurological examinations and sensitisation tests for acute and chronic pain.

They are adept at applying recognised examination and assessment approaches for patient populations at risk of underreporting their pain and can differentiate intrinsic and extrinsic risk factors in pain perpetuation for diverse patients, patient groups and pain types through screening approaches.

These members are adept at performing pain assessments in a manner consistent with principles of good pain management and demonstrate appropriate language, consultation format and communication in pain assessment.

Advanced (titled) members perform multimodal pain interventions and differentiate management strategies in acute and chronic pain, drawing on multimodal evidence based management options that could provide modulation while minimising risk. For both acute and chronic pain presentations, these members configure management plans drawing on recognised guidelines for managing various pain types.

They incorporate evidence based manual therapies, management strategies for unhelpful behaviours and beliefs, daily routine planning, lifestyle adaptions, exercise techniques, cognitive behavioural approaches, pacing and graded exposure in pain management where indicated for healing of affected nerves or sites in the body.

These members are skilled at developing pain education programs using various modes for individuals and groups with various levels of education and information requirements. They create pain self-management resources for patients. These members scope and identify additional and specific interventions offered by other health professionals for a referral pathway. They measure responses consistently throughout management using multimodal assessment and configure management approaches toward modulation as required.

These members demonstrate that they can implement a coordinated clinical approach as a member of a broader pain management team and to calibrate pain management interventions in consultation with other health professionals and assessment advice in working toward pain modulation.

Fellows

Fellows demonstrate substantial experience in and contribution to knowledge creation in pain management practice through high quality academic research, clinical publications and development of evidence-informed practice.

Appendix

Persistent pain

Persistent pain is a complex biopsychosocial problem that has a profound impact on people's lives. Persistent pain is best described as pain that continues beyond the course of injury or illness and the expected time for healing and repair. It is further defined as pain experienced every day for three months or more in the previous six months. Current understanding shows that continued activation of pain fibres has an effect on local tissues which in turn modify responses to further painful input. Here, persistent pain becomes a symptom of altered pathological processes in both peripheral and central nervous systems and not a symptom of peripheral tissue damage. As pain persists, its continuation is increasingly influenced by complex neuronal and immunological processes that serve to increase both the severity and unpleasantness of pain as well as pain-related disability as perceived by the patient. As such persistent pain has substantial psychological effects that have the potential to severely reduce quality of life and ultimately lead to depression and/or other mood disorders. These disorders can in turn influence the way pain is perceived and managed.

The following definitions have been adapted from the International Association for the Study of Pain (IASP).

Neuropathic pain

Pain caused by a lesion (where testing and examination reveals an abnormality or trauma) or disease (where an underlying cause is known) of the somatosensory nervous system that satisfies established neurological diagnostic criteria. This document aligns with the current International Association for the Study of Pain (IASP) definition of neuropathic pain, recognising that most peripheral neuralgic pain is defined by the clinical presentation rather than by objective diagnostic testing.

Visceral pain

Visceral pain results from the activation of nociceptors supplying thoracic, abdominal and pelvic viscera and results from diseases such as pancreatitis, appendicitis and diverticulitis and functional disorders such as irritable bowel syndrome and functional dyspepsia. Visceral pain is caused inflammation, ischaemia and distension of the gastrointestinal tract and associated mesenteric attachments but is relatively insensitive to other stimuli that evoke somatic pain such as cutting and burning.

Sensitisation

Increased responsiveness of nociceptive neurons to their normal input, and/or recruitment of a response to normally sub-threshold inputs.

Note: sensitisation can include a decrease in activation threshold and an increase in supra threshold response. Spontaneous discharges and increases in receptive field size may also occur. This is a neurophysiological term that can only be applied when both input and output of the neural system under study are known, e.g., by controlling the stimulus and measuring the neural event. Clinically, sensitisation may only be inferred indirectly from phenomena such as hyperalgesia or allodynia.

Central sensitisation

Increased responsiveness of nociceptive neurons in the central nervous system to their normal or subthreshold afferent input.

Note: see note for sensitisation and nociceptive neuron above. This may include increased responsiveness due to dysfunction of endogenous pain control systems. Peripheral neurons are functioning normally; changes in function occur in central neurons only.

Peripheral sensitisation

Increased responsiveness and reduced threshold of nociceptive neurons in the periphery to the stimulation of their receptive fields.

Need more information or help?

For further information, a suggestion or to discuss this topic, please:

- Email your enquiry to clinicalpolicy@osteopathy.org.au
- Call Osteopathy Australia on **1800 467 836**
- Access further information via www.osteopathy.org.au

End notes

i. **Extended practice** – refers to clinical knowledge sets and applied practice beyond the typical skill levels of graduates and osteopaths initially entering a new area of practice.

ii. **Advanced practice** – refers to clinical knowledge sets and applied practice beyond the osteopathic scope of practice and extended practice, requiring additional knowledge, skills and training more aligned with other health professionals who have depth of focus in the field of pain management.